Washington State Department of Social & Health Services

MEDICAL ASSISTANCE ADMINISTRATION
DIVISION OF CUSTOMER SUPPORT
EXCEPTION CASE MANAGEMENT
PATIENT REQUIRING REGULATION PROGRAM

PRIMARY PROVIDER SELECTION

PIC CODE
CASE NUMBER

NAME OF CLIENT LAST	FIRST	MIDDLE INITIAL	TELEPHONE NUMBER
STREET ADDRESS	CITY		ZIP CODE
			WA

To Provider(s):

The above named client is being assigned to the Patient Review and Restriction program according to WAC 388-501-0135 (printed on the back of this form). This client needs a primary care provider to manage his/her medical care and/or pharmacy to fill all prescriptions, and/or a hospital for non-emergent medical services.

This program requires the client to select a primary care provider (PCP), primary pharmacy and/or to identify a preferred hospital to receive NON-EMERGENT medical services.

Your signature on this form assures the department of your willingness to be the designated PCP, pharmacy and/or hospital. The PCP makes referrals to specialists as deemed necessary.

If you have questions, please call, _____ at (1-800-794-4360 Ext.) _____.

Please type or print the following information.

PRIMARY CARE PROVIDER - If PA or Resident, please include name of Preceptor.

NAME	PHYSICIAN	CLINIC NAME
STREET ADDRESS	CITY	STATE ZIP CODE
TELEPHONE NUMBER	MEDICAID PROVIDER NUMBER	CLINIC NUMBER
PROVIDER SIGNATURE		DATE

PHARMACY

NAME OF PHARMACY		
STREET ADDRESS	CITY	STATE ZIP CODE
TELEPHONE NUMBER	Medicaid Provider Number:	
PHARMACIST SIGNATURE		DATE

PREFERRED HOSPITAL: CLIENT PLEASE NOTE YOUR PREFERRED HOSPITAL

NAME OF HOSPITAL	TELEPHONE NUMBER
STREET ADDRESS	CITY STATE ZIP CODE

CLIENT: PLEASE SIGN AND RETURN FORM

CLIENT SIGNATURE	DATE